FEE _____ DATE _____
TRANS _____ JURIS _____
NB _____
SRTA _____
VERIF _____
DATA BANK _____
HIV/AIDS _____ CPR _____
CE HOURS _____
LICENSE NO. _____
DATE OF ISSUE _____

FOR OFFICE USE ONLY

APPLICATION TO PRACTICE DENTAL HYGIENE

COMPLETE BELOW

APPLYING FOR A LICENSE ON THE BASIS OF: _____ EXAMINATION _____ CREDENTIALS

IF APPLYING FOR LICENSURE ON THE BASIS OF EXAMINATION COMPLETE BELOW:

NAME OF REGIONAL EXAMINATION _____

DATE OF EXAMINATION _____

LOCATION OF EXAMINATION _____

Please print or type. List your name as you want it to appear on your license.

Full name for licensure _____
Last Suffix (Jr., II etc) First Middle

Maiden name and /or previous married name/s _____

Present home address _____
Number & Street City State Zip County

Address to send license _____
Number & Street City State Zip County

Phone Number _____ _____
Day Evening

Intended place of practice (if known)_____
Number & Street City State Z ip County

SSN_____-_____-_____

Place of Birth _____ Date of Birth _____ Gender M F (circle one)

Citizen of _____ If naturalized U.S. citizen give date and place _____

Color of eyes _____ Color of hair _____ Height _____ Weight _____

DENTAL HYGIENE EDUCATION

Name of School	**Location**	**No. of Years**	**Degree**	**Dates attended**
_____	_____	_____	_____	____ to ____ mo/yr mo/yr
_____	_____	_____	_____	____ to ____ mo/yr mo/yr

If you answer "NO" to any of the following questions, please provide a full explanation. **Circle One**

1. Did you complete National Boards prior to graduation from an accredited dental hygiene program? Yes No
2. Did you successfully pass a regional clinical exam within three (3) tries? Yes No

OTHER STATE LICENSES

List all states in which you have held or presently hold a dental hygiene license. Use additional sheets if necessary.

STATE	LICENSE NUMBER	STATE	LICENSE NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRACTICE HISTORY

Give places of practice since graduation. List most recent first. Use additional sheets if necessary.

ADDRESS	ASSOCIATE'S NAMES (If applicable)	DATES
_____	_____	____ to ____ mo/yr mo/yr
_____	_____	____ to ____ mo/yr mo/yr
_____	_____	____ to ____ mo/yr mo/yr

If you answer "YES" to any of the following questions, provide a full explanation on separate sheet.

		(Circle one)	
(1.)	Has any dental hygiene license held by you had any type of disciplinary action taken against it by any state board or government agency?	Yes	No
(2.)	Are there any disciplinary actions pending against your license by any state board or government agency?	Yes	No
(3.)	Has a dental hygiene license been denied you in any state?	Yes	No
(4.)	Have you ever voluntarily surrendered your license while under investigation?	Yes	No
(5.)	Have you been convicted of a misdemeanor or felony?	Yes	No
(6.)	Have you ever been sued for malpractice or professional negligence?	Yes	No
(7.)	Do you currently have an obligation in a financial aid program administered by the Kentucky Higher Education Assistance Authority (KHEAA)?	Yes	No
(8.)	If yes to #7, are you in default of the repayment obligation? (per KRS 164.772)	Yes	No

Submit a head and shoulders photograph taken within the past six months. Please place photograph in the box provided. No hats please.

Passport size photo

NOTARY

STATE OF _____

COUNTY OF _____

On this _____ day of _____ 20 _____ the undersigned personally appeared before me, and being duly sworn, says that he/she is the person referred to in this application and that the foregoing statements are true in every respect, and that the attached photograph is a true likeness of himself/herself taken within the last six months.

He/she has carefully read the questions in the foregoing application and has answered them truthfully, fully and completely. He/she understands that failure to make a full disclosure of any fact or information called for may result in the denial of licensure. Applicant authorizes all educational institutions, governmental agencies, instrumentalities, employers, and business and professional associates (past and present), to release to the Kentucky Board of Dentistry any information, files or records requested by the Board in connection with the processing of this application.

Signature of applicant_____

Sworn to and subscribed before me, this _____ day of _____ 20____

SEAL

Signature of Notary _____

My commission expires _____

To request special accommodations for a disability if you are taking the Southern Regional Testing Examination please call (804) 428-1003.

NOTE: Make all checks or money orders payable to the Kentucky Board of Dentistry and submit application and fee to :

KENTUCKY BOARD OF DENTISTRY
312 WHITTINGTON PKWY, SUITE 101
LOUISVILLE, KENTUCKY 40222
(502) 429-7280